

# Dental Patient Registration

# MIT Medical Department

**Patient name** \_\_\_\_\_ Date \_\_\_\_\_  
Sex  male  female Date of birth \_\_\_\_\_ Social security number \_\_\_\_\_  
MIT ID number \_\_\_\_\_ **E-mail address** \_\_\_\_\_

**Local address/telephone** \_\_\_\_\_  
\_\_\_\_\_ ( ) \_\_\_\_\_  
city state zip code telephone number

**Permanent address** \_\_\_\_\_  
(if different from local address)

**Work address/telephone** \_\_\_\_\_ ( ) \_\_\_\_\_  
(if at MIT, give building & room) work telephone

**Emergency contact** \_\_\_\_\_ ( ) \_\_\_\_\_  
(person to notify in case of emergency) relationship telephone number

**Health insurance plan and certificate number** \_\_\_\_\_  
\_\_\_\_\_

**Primary dental insurance** \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Certificate/subscriber number \_\_\_\_\_ Group# \_\_\_\_\_  
Subscriber name \_\_\_\_\_  
Subscriber address \_\_\_\_\_ last first mi relationship to subscriber  
Subscriber employer \_\_\_\_\_

**Secondary dental insurance** \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Certificate/subscriber number \_\_\_\_\_ Group# \_\_\_\_\_  
Subscriber name \_\_\_\_\_  
Subscriber address \_\_\_\_\_ last first mi relationship to subscriber  
Subscriber employer \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

**How is patient a member of the MIT community?**

<b>Patient is:</b>	<input type="checkbox"/> Registered MIT <b>Student</b>	<input type="checkbox"/> Spouse or	<input type="checkbox"/> Child of <b>Student</b>
	<input type="checkbox"/> MIT or Lincoln <b>Employee</b>	<input type="checkbox"/> Spouse or	<input type="checkbox"/> Child of <b>Employee</b>
	<input type="checkbox"/> Draper <b>Employee</b>	<input type="checkbox"/> Spouse or	<input type="checkbox"/> Child of Draper <b>Employee</b>
	<input type="checkbox"/> <b>Retired</b> Employee	<input type="checkbox"/> Spouse or	<input type="checkbox"/> Child of <b>Retired</b> Employee
	<input type="checkbox"/> <b>Whitehead</b> Employee	<input type="checkbox"/> Spouse or	<input type="checkbox"/> Child of <b>Whitehead</b> Employee
	<input type="checkbox"/> <b>Other affiliation and/or relationship</b> (please specify)		

\_\_\_\_\_

**If student**, please complete  
Expected date of graduation \_\_\_\_\_  
Name of school \_\_\_\_\_ City \_\_\_\_\_

**If spouse or child**, please complete  
Name of affiliated spouse or parent \_\_\_\_\_ ID number \_\_\_\_\_  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
day telephone evening telephone

## Signature

I agree to pay for any services not paid for by my insurance

X \_\_\_\_\_  
patient signature

\_\_\_\_\_ Medical Department registration person